Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Petitioner is a health maintenance organization that administers an "employee benefit plan" within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). Petitioner was sued in a third-party complaint in a negligence action because, when the subscriber's treating physician sought pre-authorization from petitioner to transfer the subscriber to a particular hospital, petitioner declined to provide that authorization. The sole basis for that refusal was that the proposed transferee hospital did not participate in petitioner's HMO network. Instead, petitioner advised the physician that the subscriber could be transferred to any of three other hospitals in the area that were participants in petitioner's network. The Pennsylvania Supreme Court broadly held that state law "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," and are therefore not preempted by Section 514(a) of ERISA. The question presented is:

> Does Section 514(a) of ERISA preempt state law claims arising from a health maintenance organization's alleged negligence in its administration of benefits under an ERISA-governed health plan?

RULE 14.1(b) and 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner United States Healthcare Systems of Pennsylvania, Inc., states that the other parties to this action are Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund. Basile Pappas and Theodora Pappas were plaintiffs in the trial court, but their claims against defendants Dr. David S. Asbel and Haverford Community Hospital were settled. App. 45a-46a. As a result of the settlement, Mr. and Mrs. Pappas and Dr. Asbel are no longer parties to this litigation. Subsequent to the settlement, respondents Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund, who were the insurers for defendant Haverford Community Hospital, were substituted as the real parties in interest for the Hospital. App. 45a-46a.

Pursuant to Rule 29.6, petitioner states that the parent companies of United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") are Aetna U.S. Healthcare, Inc. and, ultimately, Aetna, Inc. U.S. Healthcare does business as the Health Maintenance Organization of Pennsylvania; it has no subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the Pennsylvania Supreme Court in this case.

OPINIONS BELOW

The opinion of the Pennsylvania Supreme Court is reported at 724 A.2d 889. App. la-16a. The opinion of the Pennsylvania Superior Court reinstating the third-party complaint by Defendant Haverford Community Hospital against petitioner is reported at 450 Pa. Super. 162, 675 A.2d 711 (1996). App. 20a-33a. The opinion of the Court of Common Pleas of Delaware County granting petitioner's motion for summary judgment on the third-party complaint is unreported. App. 34a-44a.

JURISDICTION

The Pennsylvania Supreme Court rendered its decision on December 23, 1998, and denied petitioner's Application for Reargument on February 12, 1999. App. 2a, 62a. This Court's jurisdiction is invoked under 28 U.S.C. § 1257. *See Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 482-483 (1975).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., art. VI, cl.2.

Section 514(a) of ERISA states that "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . " 29 U.S.C. § 1144(a).

STATEMENT

A. Factual Background

Basile Pappas was a subscriber of the Health Maintenance Organization of Pennsylvania ("HMO Pa.")[1] through an employee welfare benefit plan provided to his wife by her employer. App. 35a-36a. HMO Pa. administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

[1] HMO Pa. is a subsidiary of petitioner. App. 36a.

On May 20, 1991, Mr. Pappas went to his primary-care physician, Dr. David Asbel, complaining of neck and shoulder pain. App. 48a. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of steroids. *Id.* The next morning, Mr. Pappas was unable to walk and was experiencing numbness in his extremities. App. 49a. He was transported by ambulance to Haverford Community Hospital ("Haverford"). *Id.* The emergency room physician at Haverford, Dr. Steven Dickter, concluded that Mr. Pappas was suffering from an epidural abscess which pressed upon his spinal column. App. 36a. Dr. Dickter concluded that Mr. Pappas should be treated at a "university" hospital, which would have more extensive facilities than Haverford. *Id.*

Dr. Dickter decided to transfer Mr. Pappas to Jefferson University Hospital ("Jefferson"). *Id.* When the ambulance arrived at Haverford at 12:40 p.m. to pick up Mr. Pappas, Dr. Dickter was informed by the ambulance personnel that Jefferson was not an HMO Pa. participating hospital, meaning that it was not one of the hospitals with which HMO Pa. contracts to provide hospital services to its plan members. App. 21a, 36a. At 12:50 p.m., Dr. Dickter telephoned HMO Pa. to inquire as to Jefferson's status with HMO Pa. *Id.* Within fifteen minutes, HMO Pa. advised Dr. Dickter that coverage would not be provided for treatment at Jefferson, since it was not a participant in HMO Pa.'s network, but that there were three HMO Pa. participating hospitals in the vicinity (Temple University, Hahnemann University ("Hahnemann") and Medical College of Pennsylvania) to which Mr. Pappas could be transferred. App. 21a, 36a. No allegation has been made that these three hospitals were

inferior to Jefferson, or that they were not appropriately equipped and staffed to treat Mr. Pappas' medical condition.

Thereafter, Dr. Dickter of Haverford called Dr. Asbel, Mr. Pappas' primary physician, to ascertain Dr. Asbel's preference concerning his patient's destination. App. 36a. Dr. Asbel expressed a preference for Hahnemann, but Hahnemann delayed in responding to Dr. Dickter's inquiry concerning its intensive care unit bed space availability. App. 37a. At approximately 2:20 p.m., Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before Hahnemann could determine whether it had bed space for Mr. Pappas. *Id.* As a result of Hahnemann's delays, Dr. Dickter then called Medical College of Pennsylvania, where Mr. Pappas was transported. *Id.*

Mr. Pappas and his wife brought a medical malpractice action against Dr. Asbel and Haverford, alleging that their delay in transferring Mr. Pappas to a hospital capable of treating his condition caused his spinal cord compression to continue and led to quadriplegia. App. 47a-58a. Mr. and Mrs. Pappas did not sue petitioner. Haverford then filed a third-party complaint for contribution and indemnification against petitioner, complaining that "HMO-PA refused to authorize transfer of [Mr. Pappas] to a hospital selected by physicians at Haverford Community Hospital," namely, Jefferson. App. 60a. Haverford also incorporated the allegation in the Pappas' Complaint that there was an inordinate delay in transferring Mr. Pappas from Haverford to a more suitable hospital. *Id.* The sole basis for petitioner's alleged liability to Haverford was petitioner's administrative decision to

refuse coverage for treatment at Jefferson because it was a non-participating hospital.

B. Procedural History

Petitioner moved for summary judgment on the third-party complaint by Haverford on the grounds that all of Haverford's claims were preempted by Section 514(a) of ERISA. The trial court granted that motion, stating that Haverford's allegations against petitioner "fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision." App. 41a. The court further stated as follows: "Haverford Hospital seems to suggest that [petitioner] is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under [petitioner's] programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan." App. 43a.

The plaintiffs' claims against Dr. Asbel and Haverford were settled, and thereafter the trial court entered an order substituting Haverford's insurers, Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund"), for Haverford as the real parties in interest. App. 45a-46a.

PHICO and the CAT fund appealed the summary judgment order to the Pennsylvania Superior Court, which reversed the trial court and found no preemption

of Haverford's claims against petitioner under Section 514(a) of ERISA. App. 18a-33a. According to the Superior Court, "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's" are not encompassed within the preemptive ambit of Section 514(a) of ERISA. App. 27a.

The Pennsylvania Supreme Court, although disagreeing with the reasoning of the Superior Court, affirmed its decision that Haverford's claims against petitioner were not preempted by Section 514(a) of ERISA. App. 1a-16a. The Pennsylvania Supreme Court acknowledged that this Court gave a "deliberately expansive" interpretation to the preemption provision in Section 514(a) of ERISA in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). App. 6a-7a. However, the Pennsylvania Supreme Court expressly declined to follow those decisions, asserting that they were overruled *sub silentio* in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997). App. 7a-11a.

In a sweeping pronouncement that it did not confine to the particular facts of this case, the Court stated that "[b]ased upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App. 11a. The Court did not draw any distinction between negligence claims arising from an HMO's administration of plan benefits, such as the instant case,

and negligence claims based on an HMO's purported vicarious liability for providers' malpractice. Instead, the Court's broad holding appears to preclude an HMO from invoking the preemption provision of Section 514(a) under any set of circumstances where it has been sued for negligence.[2]

REASONS FOR GRANTING THE PETITION

I. The Decision Below Conflicts With This Court's Decisions Construing Section 514(a) of ERISA

The third-party complaint by Haverford against petitioner challenges a straightforward and commonplace ERISA plan benefits determination: coverage would be provided to Mr. Pappas if he was transferred to any of three specified hospitals that had contracted with petitioner to provide hospital services to plan members, but would not be provided if he was transferred to Jefferson, which had no such contractual relationship with petitioner. Since Haverford's negligence claim against petitioner arises from and directly relates to the administration of benefits under the ERISA-governed health plan, it falls squarely within the preemptive scope of Section 514(a) of ERISA.

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[2] The broad sweep of the Court's ruling is further reflected in its statement that the issue it was resolving was "whether negligence claims against a health maintenance organization 'relate to' an ERISA plan." App. 6a. The factual circumstances giving rise to the negligence claim appear not to make any difference to the Court's conclusion that any such claim is not preempted.

The Pennsylvania Supreme Court's decision directly conflicts with this Court's decision in *Pilot Life*. In *Pilot Life*, plaintiff had alleged that an insurance company engaged in the processing and review of claims for benefits under an employee benefit plan had acted tortiously when it terminated his disability benefits. Relying on *Metropolitan Life* and *Shaw*, this Court emphasized the "expansive sweep of the pre-emption clause" in Section 514(a) of ERISA. 481 U.S. at 47. The Court noted that the legislative history of ERISA reflects "both the breadth and importance of the pre-emption provisions." *Id.* at 46. The Court held that "[t]he common law causes of action raised in Dedeaux's complaint, each *based on alleged improper processing of a claim for benefits under an employee benefit plan*, undoubtedly meet the criteria for pre-emption under § 514(a)." *Id.* at 48 (emphasis added).

The Pennsylvania Supreme Court's decision also conflicts with this Court's decisions in *Metropolitan Life* and *Shaw*. In both of those cases, this Court held that ERISA preempts state laws that require an ERISA-governed plan to provide certain types of coverage, because such a requirement "bears indirectly but substantially on all insured benefit plans . . . " *Metropolitan Life*, 471 U.S. at 739. The Pennsylvania Supreme Court's ruling subjects petitioner and other health maintenance organizations to tort liability for failing to authorize a member's treatment at a non-participating hospital. In essence, the decision imposes a substantive coverage requirement on ERISA-governed health plans: either permit a member to be admitted to whatever hospital the treating physician selects – regardless of whether that hospital participates in the health maintenance organization's network – or

face liability in tort for damages. Such a result cannot be reconciled with this Court's decisions in *Metropolitan Life* and *Shaw*. Moreover, it would wreak havoc on the federal and state HMO laws requiring plans to establish networks of participating providers. *See* 42 U.S.C. § 300e; 28 Pa. Code § 9.75.

The Pennsylvania Supreme Court tacitly acknowledged that the third-party complaint against petitioner would be preempted under *Pilot Life*, *Shaw* and *Metropolitan Life*, but it expressly declined to follow those decisions, characterizing them as "superannuated." App. 9a. Instead, it took the view that this Court "noticeably changed tack" in *Travelers* by adopting a "new position on ERISA preemption," and it further opined that "*Travelers* and its progeny [*Dillingham* and *DeBuono*] have thrown the expansive holdings of those earlier cases into question." App. 7a, 9a, 10a-11a. The Pennsylvania Supreme Court relied very heavily on the concurring opinion in *Dillingham* by Justice Scalia (joined by Justice Ginsburg), and it asserted that Justice Scalia had "reproached the Court for not forthrightly acknowledging that the holdings of these older cases 'have in effect been abandoned.' " App. 9a. However, the Pennsylvania Supreme Court truncated its quotation of Justice Scalia's comment, deleting the earlier part of his sentence in which he noted that the Court's opinion in *Dillingham* "does obeisance to all our prior cases." 519 U.S. at 335. Justice Scalia also stated in his concurring opinion in *Dillingham* that the majority opinion "is a fair description of our prior case law, and a fair application of the more recent of that case law" (*id.*), thereby acknowledging that *Pilot Life* remained good law.

Similarly, contrary to the Pennsylvania Supreme Court's erroneous belief, this Court's decision in *Travelers* did not overrule *Pilot Life, Shaw* or *Metropolitan Life*, either expressly or by implication. To the contrary, the *Travelers* opinion concludes by expressing "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. The continuing vitality of *Pilot Life* and *Metropolitan Life* was most recently evidenced by this Court's decision in *UNUM Life Ins. Co. of America v. Ward*, ___ U.S. ___, 67 U.S.L.W. 4243 (April 20, 1999).

In addition to *Travelers*, the Pennsylvania Supreme Court relied on *DeBuono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806 (1997) in support of its contention that this Court's earlier decisions in *Pilot Life, Shaw* and *Metropolitan Life* had been tacitly overruled. However, in *DeBuono*, this Court emphasized that these cases were *not* overruled, saying that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' . . . ERISA benefit plans." *Id.* at 813. Here, too, it is not necessary to rely on an expansive interpretation of "relate to" in order to find preemption, because the negligence claim at issue arises directly from the petitioner's administration of benefits under the plan. Allegations that petitioner should have pre-approved Mr. Pappas' admission at a non-participating hospital and that it delayed unduly in advising the treating physician as to the participating hospitals to which Mr. Pappas could be transferred have a clear and direct "connection with or reference to" Mr. Pappas' benefit plan, and thus are preempted.

Travelers involved a state law having only a peripheral connection with ERISA benefit plans; significantly, the Court contrasted the statute before it with earlier cases where "ERISA pre-empted state laws that mandated employee benefit structures or their administration." 514 U.S. at 658. *Accord UNUM Life Ins. Co. of America v. Ward*, 67 U.S.L.W. at 4249 (a California rule deeming the employer the agent of the insurer "would have a marked effect on plan administration," and thus "relate[s] to" an ERISA plan under Section 514(a)). Here, subjecting petitioner to potential liability in tort on account of its refusal to pre-authorize a subscriber's admission to a non-participating hospital is tantamount to "mandat[ing] employee benefit structures or their administration," and thus is preempted by Section 514(a) of ERISA.

Moreover, the Pennsylvania Supreme Court was not free to disregard *Pilot Life*, *Shaw* and *Metropolitan Life* simply because it believed them to be "superannuated." App. 9a. This Court has admonished lower courts not to anticipate the overruling of its precedents, stating that "[o]ur decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn v. United States*, 524 U.S. 236, 118 S.Ct. 1969, 1978 (1998). *Accord Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989) ("[i]f a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower court] should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.").

The pernicious effect of anticipatory overrulings of this Court's precedents by lower courts is not merely that it usurps this Court's unique prerogative. Such overrulings – unless corrected by this Court – also force litigants to proceed under a view of the law that may very well prove to be wrong. For example, in *United States v. International Business Machines Corp.*, 517 U.S. 843 (1996), the lower court was of the view that one of this Court's Export Clause precedents might have been superseded by later precedents. Had the court of appeals done what the Pennsylvania Supreme Court did in this case, IBM would have had a substantial tax liability to the federal government, yet this Court ultimately concluded (by a 6-2 vote) that the questioned precedent was not an "anachronism in need of modernization," *id.* at 850, and IBM prevailed. *See also Rodriguez de Quijas*, 490 U.S. at 486 (Stevens, J., joined by Brennan, Marshall & Blackmun, JJ., dissenting) (criticizing as "an indefensible brand of judicial activism" the lower court's failure to follow a Supreme Court precedent thought to have been superseded by later decisions). This Court should not sit idly by while the Pennsylvania Supreme Court reaches conclusions that directly contradict un-overruled decisions of this Court, and are also wrong.

The Pennsylvania Supreme Court's unprecedented holding that any and all negligence actions against health maintenance organizations do not "relate to" an ERISA plan stands in direct conflict with this Court's decision in *Pilot Life*, where this Court held that Section 514(a) preempts suits alleging improper processing of a claim for benefits. A cause of action predicated on a health maintenance organization's alleged negligence in administering

benefits under an ERISA-governed plan plainly "relates to" the plan, and is therefore preempted under Section 514(a) of ERISA.

II. The Decision Below Conflicts With Decisions By The Third Circuit And Numerous Other Courts of Appeals Throughout The Country

Conspicuous by its absence from the decision below is the citation of *any* case from any court that supports the Pennsylvania Supreme Court's sweeping pronouncement that all negligence claims against health maintenance organizations fall outside the preemptive scope of Section 514(a). Indeed, the Pennsylvania Supreme Court did not and could not cite any cases to support its unprecedented holding, because none exists.

The Pennsylvania Supreme Court's ruling conflicts with the Third Circuit's decision in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995), creating an unseemly split between the state and federal courts in Pennsylvania in construing Section 514(a) of ERISA. Resolution of this conflict is necessary to prevent forum shopping. *See Yee v. Escondido*, 503 U.S. 519, 538 (1992) (granting certiorari to resolve conflict between Ninth Circuit and California state courts, this Court noted that "[f]orum shopping is thus of particular concern"); *Baldwin v. Alabama*, 472 U.S. 372, 374 (1985) (granting certiorari to resolve conflict between Eleventh Circuit and Supreme Court of Alabama).

In *Dukes*, the Third Circuit held that Section 502(a) of ERISA completely preempts claims based on utilization review decisions and other plan benefit determinations,

but does not completely preempt claims challenging the quality of care a subscriber receives.[3] The Pennsylvania Supreme Court's declaration that *all* negligence claims against a health maintenance organization are outside the preemptive scope of Section 514(a), even if they relate to the administration of benefits under a plan, is in direct conflict with *Dukes*. *See Huss v. Green Spring Health Services, Inc.*, No. 98-6055, 1999 U.S. Dist. LEXIS 5101 at *13 (E.D. Pa. April 16, 1999) (noting the "tension" between *Dukes* and the Pennsylvania Supreme Court's decision in this case and following *Dukes*). Remarkably, the Pennsylvania Supreme Court's opinion made absolutely no mention of *Dukes*; it simply ignored the suggestion by Justice Nigro in his concurring opinion to adopt the rationale of the *Dukes* decision.[4] App. 16a.

The Pennsylvania Supreme Court acknowledged that there are a number of federal appellate decisions holding

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[3] The *Dukes* holding that Section 502(a) of ERISA completely preempts claims arising from utilization review decisions and plan benefit determinations means that such claims are also preempted under Section 514(a) of ERISA. It is well-settled that "[w]here a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Rice v. Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995).

[4] Justice Nigro asserted that, under the *Dukes* analysis, the third-party negligence claim against petitioner for refusing to pre-authorize coverage at Jefferson on account of its status as a non-participating hospital would not be preempted. App. 16a. However, that conclusion rests on a fundamental misunderstanding of *Dukes*. The Third Circuit held in *Dukes* that ERISA preempts claims arising from "pre-certification review" decisions by a plan administrator on requests for advance approval of hospital stays and medical procedures, which is precisely what has been challenged here. 57 F.3d at 359.

that Section 514(a) preempts negligence claims against health maintenance organizations which, like the claim asserted here against petitioner, arise from the administration and processing of claims for benefits under an ERISA-governed plan. App. 11a n.5. However, just as it refused to follow this Court's pre-*Travelers* decisions because it believed they were no longer good law, so too did it disregard the many relevant court of appeals' decisions, declaring that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." *Id.*

In fact, subsequent to *Travelers*, the federal courts of appeals have uniformly continued to hold that, under *Pilot Life*, Section 514(a) preempts claims arising from the administration of benefits under an ERISA plan, such as refusals to authorize coverage for a particular type of treatment or refusals to authorize coverage at a particular hospital. *See Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9th Cir. 1998) (claims arising from delay in authorizing bone marrow transplant were preempted, because "Prudential's alleged breach of fiduciary duty while administering the benefit plan is conduct covered by ERISA"); *Cannon v. Group Health Serv.*, 77 F.3d 1270, 1273 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996) (ERISA preempted suit arising from delay in authorizing bone marrow transplant, since the suit arose from "the improper processing of Mrs. Cannon's benefit claim"); *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997), *cert. denied*, 118 S.Ct. 1512 (1998) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant, since "a plan

administrator's refusal to pay allegedly promised benefits" is "related to" an employee benefit plan); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1516 (1998) (ERISA preempted claim stemming from refusal to authorize coverage for high dose chemotherapy cancer treatment); *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1353 (11th Cir. 1998) (ERISA preempted tort challenge to plan's decision to deny plaintiff's claim for benefits); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (ERISA preemption applies to "allegations of negligence based on a failure to treat where the plan denied benefits for the proposed treatment"); *Parrino v. FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.), *cert. denied*, 119 S.Ct. 510 (1998) (ERISA preempted suit arising from plan administrator's delay in authorizing coverage for proton beam therapy, since plaintiff's claims "are predicated upon alleged improper handling of [plaintiff's] claim for treatment . . . ").

The Pennsylvania Supreme Court's decision also conflicts with a number of pre-*Travelers* court of appeals decisions which, relying upon *Pilot Life*, had found that ERISA preempted claims based on the alleged improper administration of benefits under a plan. *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994) (plan refused to certify payment for heart surgery at a hospital outside the plan's service area; "the decision not to precertify payment relates directly to Lincoln National's administration of benefits"); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992) (plan authorized home nursing care for pregnant woman

rather than hospitalization; "the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination"); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994) (ERISA preempted claim based on delay in authorizing coverage for bone marrow transplant; plaintiff's claim "seeks damages for the negligent administration of benefit claims"); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (claim based on allegedly unlawful termination of coverage was preempted; "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan . . . "); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (ERISA preempted claims arising from refusal to authorize psychiatric treatment under the plan; "American Biodyne and its employees were determining what benefits were available to Tolton under the plan.").

Petitioner's decision that Mr. Pappas would be afforded coverage if he was transferred to any of the three designated participating hospitals (Hahnemann, Temple University or Medical College of Pennsylvania), but not if he was transferred to a non-participating hospital (Jefferson), represents a prototypical administration of benefits determination. The negligence claim by Haverford attacking that benefits determination should have been found preempted in accordance with *Pilot Life* and all of the court of appeals' decisions cited above. The Pennsylvania Supreme Court's aberrational ruling that even administration of benefits determinations are not encompassed within the preemptive sweep of Section 514(a) has created a conflict that warrants certiorari.

The third-party complaint brought by Haverford complains not only of petitioner's refusal to pre-authorize coverage for Mr. Pappas at Jefferson, but also alleges that petitioner contributed to the delay in transferring Mr. Pappas from Haverford to a more suitable hospital.[5] App. 60a. The Pennsylvania Supreme Court stated that "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care" and are not preempted. App. 11a-12a. However, that ruling conflicts with five of the federal appellate decisions cited above, where the courts of appeals held that, under *Pilot Life*, ERISA preempts claims based on undue delays by plan administrators in approving particular treatments or benefits. *Bast v. Prudential Ins. Co.*, 150 F.3d 1003; *Cannon v. Group Health Service*, 77 F.3d 1270; *Kuhl v. Lincoln Nat. Health Plan*, 999 F. 2d 298; *Spain v. Aetna Life Ins.*, 11 F.3d 129; *Parrino v. FHP, Inc.*, 146 F.3d 699.

The decision below stands alone in its wholesale evisceration of the preemption defense that other courts have upheld for ERISA plan benefit determinations. The conflict between the Pennsylvania Supreme Court's decision and all of the federal court of appeals' decisions referred to above is stark, and that conflict can only be resolved by this Court.

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[5] It took petitioner only fifteen minutes to provide Dr. Dickter with the names of three participating hospitals at which coverage for Mr. Pappas would be pre-approved. App. 21a, 36a.

III. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In The Lower Courts

Although this Court has rendered decisions in 17 cases addressing the boundaries of ERISA's preemptive reach,[6] it has not yet addressed ERISA preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations.

Lacking guidance from this Court, the federal and state courts have struggled mightily with the interplay of the preemption provision in Section 514(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. The courts have employed differing analytical frameworks, have reached widely divergent conclusions, and have created tremendous confusion, uncertainty and unpredictability in a vitally important area of the law that affects the tens of millions of people who participate in managed health care. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit

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[6] *See DeBuono*, 520 U.S. at 808 n.1 and *UNUM Life Ins. Co. v. Ward*, ___ U.S. ___, 67 U.S.L.W. 4243 (April 20, 1999).

plans obtained through a qualified employer are within the scope of ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO or a self-funded plan.

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework . . . through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers . . . " B. Richardson, *Health Care: ERISA Preemption and HMO Liability – A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 Okla.L.Rev. 677, 679 (1996). The "myriad of confusion" that now exists in the federal and state courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

A very recent article points out that "[w]ith no specific guidance from the Supreme Court in this area, lower courts have floundered and strained" and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow and L. Greenlees, "ERISA Pre-emption – A Law in Search of a Doctrine," 27 Health Law Digest No. 3 (March, 1999) at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption

> issues. Second, the courts will continue to struggle by drawing distinctions – some meaningful, some not – in the hope of reaching results that are both equitable and in accord with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. *Accord* K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption,* 13 Yale J. on Reg. 255, 304 (1996) (after analyzing the numerous cases considering ERISA preemption of tort claims against HMOs, author concludes that "the outcomes on the issue of ERISA preemption have been inconsistent – indeed, the situation might be characterized as one of utter confusion on the issue"); P. Jacobson and S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence,* 35 Hous.L.Rev. 985, 1032 (1998) (lacking Supreme Court guidance, lower court decisions considering ERISA preemption in context of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity – exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here – Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs,* 30 Ga.L.Rev. 1023, 1051 (1996) (observing that courts have adopted divergent approaches in handling the issue of whether ERISA preempts malpractice claims against HMOs, and

"these various approaches have created incongruity and analytical inconsistency among courts").

ERISA preemption in the context of malpractice and negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal and state courts until this Court steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the lower courts in grappling with this difficult issue.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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[J-97-1997]

IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS and THEODORA PAPPAS, H/W,	:	No. 98 Eastern District Appeal Docket 1996
Plaintiffs,	:	Appeal from the Orders of the Superior Court Filed March 15, 1996 and May 23, 1996 at No. 2617 Philadelphia 1995, reversing the Order of the Court of Common Pleas of Delaware County at No. 92-3903
v.	:	
DAVID S. ASBEL, D.O.,	:	
Defendant,	:	
PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),	:	450 Pa. Super. 162, 675 A.2d 711 (1996).
	:	ARGUED: April 30, 1997
Defendants/Appellees	:	
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,	:	
Additional Defendant/ Appellant	:	

OPINION OF THE COURT

MR. JUSTICE CAPPY DECIDED: December 23, 1998

This is an appeal from the order of the Superior Court reversing the trial court's entry of summary judgment in favor of third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"). The issue on which this court granted allocatur is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, *et seq.*, preempts the state tort law claims brought against U.S. Healthcare. For reasons which differ from those relied upon by the Superior Court, we find that ERISA does not preempt these claims. We therefore affirm the order of the Superior Court.

At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.

Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further

treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:15 p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed

a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however, determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

In reviewing whether a trial court's award of summary judgment was appropriate, we view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre,* 532 Pa. 142, 144-145, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead*

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[1] It is uncontested that U.S Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

Industries Assoc., Inc., 547 Pa. 224, 230, 690 A.2d 169, 171 (1997). As the issue presented in this case is one of law, our scope of review is plenary. *See Phillips v. A-BEST Products Co.*, 542 Pa. 124, 130, 665 A.2d 1167, 1170 (1995).

Our analysis begins with a review of the basic principles of preemption law. The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; . . . any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const., art. VI, cl. 2. It is this clause which gives to the United States Congress power to preempt state law.

In determining whether state law is preempted by a federal law, a reviewing court is cautioned that such a review "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless it [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407, 422 (1992) (citations omitted). Thus, Congress' intent is the "ultimate touchstone" in this analysis. *Id.*

A state law can be preempted in one of three ways. The first is where the United States Congress enacts a provision expressly preempting state law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n*, 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). Even where there is no explicit preemption provision, preemption will still be found where Congress has legislated the field so comprehensively that it has implicitly communicated the intent to occupy a given field to the exclusion of state law. *Schneidewind v.*

ANR Pipeline Co., 485 U.S. 293, 299-300, 1008 S.Ct. 1145, 1150, 99 L.Ed.2d 316, 325 (1988). Finally, a state law will be preempted where a state law actually conflicts with federal law. *Id. See also Cellucci v. General Motors Corp.*, 1998 WL 1333 (Pa. 1998).

It is this first method of preemption which is at issue in this matter. The express preemption provision in question states that "the provisions of this title . . . shall supersede any and all State laws[3] insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a).

None of the parties in this matter dispute that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against a health maintenance organization "relate to" an ERISA plan. U.S. Healthcare, however, cites to several United States Supreme Court cases from the 1980's and early 1990's as support for its contention that these claims should be preempted by ERISA.

U.S. Healthcare is indeed accurate in its claim that the Supreme Court had given the ERISA preemption provision an almost breathtaking scope in the 1980's and early 1990's. The Court stated that the preemption provisions were "deliberately expansive". *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39, 49 (1987). The Court at that time held the opinion that

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[3] "State law" was defined by Congress as including "all laws, decisions, rule, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1). It is uncontested that a decision handed down by a state court, which would enter the common law of that state, is a "State law" as defined by ERISA.

"[t]he breadth of [§ 1144(a)'s] preemptive reach is apparent from that section's language." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490, 501 (1983). It declared that the words of the preemption provision were to be given their "broad commonsense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388, 85 L.Ed.2d 728, 740 (1985) (citations omitted). In the vast majority of cases concerning ERISA preemption addressed by the Court during this period, it was found that the state laws being reviewed had some "connection with" or "reference to" the ERISA plan. Although the Court did concede that the ERISA preemption provision "perhaps [is] not the model of legislative drafting" that the Court would hope for, *Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552, 95 L.Ed.2d at 47, the Court in the 1980's and early 1990's did not admit to any possibility that the plain meaning of the words of the preemption provision could not be given effect.

The Court noticeably changed tack in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). In *Travelers*, the unanimous Court determined that a New York statute which required hospitals to collect surcharges from patients covered by all commercial insurers other than Blue Cross/Blue Shield was not preempted by ERISA. After years of striving to make sense of the plain language of the preemption provision, the Court frankly admitted that the text is "unhelpful". *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705. The Court recognized that

"[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.' " *Id.* at 655, 115 S.Ct. at 1677, 131 L.Ed.2d at 705 (citations omitted). The Court reasoned that the language of the preemption provision is so extensive that if the Court were to look merely to the bare language of the provision, the provision would for all intents and purposes be without limit – an intent which the Court would not ascribe to Congress. *Id.* The Court concluded that "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line here," and that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705.

The Court determined that the "basic thrust of the preemption provision . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657, 115 S.Ct. at 1677-1678, 131 L.Ed.2d at 706. It recognized fairly significant bounds on the preemption provision when it stated that "[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability. " *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709 (citation omitted). The Court also cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically

has been a matter of local concern." *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709 (citations omitted).

The cases following *Travelers* have continued this trend. In *California Division of Labor Standards Enforcement v. Dillingham Construction, NA., Inc.*, ___ U.S. ___, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997), the majority relied upon *Travelers* to find that a California prevailing wage law was not preempted by ERISA. It is in the concurring opinion authored by Mr. Justice Scalia, however, that we find the most cogent recognition that the law of ERISA preemption had, in effect, been changed by *Travelers*. Mr. Justice Scalia opined that the cases from the 1980's and early 1990's, which were premised upon the now rejected notion that the plain language of the ERISA preemption provision could be given effect, were superannuated. He reproached the Court for not forthrightly acknowledging that the holdings of these older cases "have in effect been abandoned." *Id.* at ___, 117 S.Ct. at 843, 136 L.Ed. at 806 (Scalia, J., concurring). He believed that since *Travelers* recognized that literal interpretation of the provision "relate to" was unworkable, then earlier cases which concluded that the plain language of the preemption provision justified findings that the provision had "broad scope" and was "conspicuous for its breadth" were simply no longer good law. *Id.*

This new position on ERISA preemption was reiterated in *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, ___ U.S. ___, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997). The question presented in *De Buono* was whether a New York gross receipts tax could be applied to hospitals operated by ERISA plans. The Court again stated that the language "relates to" was unhelpful and that it must

instead explore Congress' intent in enacting ERISA in order to determine if a state law would indeed fall within ERISA's preemptive scope. *Id.* at ___, 117 S.Ct. at 1751, 138 L.Ed.2d at 29. The Court determined that the gross receipts tax was not preempted by ERISA because it was "one of myriad state laws of general applicability that impose (sic) some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute. . . . Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *Id.* at ___, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31 (citations omitted).[4]

Thus, although U.S. Healthcare is correct when it states that U.S. Supreme Court decisions from the 1980's and early 1990's support its position that the preemption provision is to be read broadly, *Travelers* and its progeny have thrown the expansive holdings of those earlier cases

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[4] We note that another case concerning ERISA preemption was decided the same day *De Buono* was handed down. *Boggs v. Boggs*, ___ U.S. ___ 118 S.Ct. 9, 138 L.Ed.2d 1043 (1997). *Boggs*, however, does not lend anything to the analysis of the matter *sub judice*. In *Boggs*, the Court determined that Louisiana common law was preempted as it was in direct conflict with §§ 1055 and 1056 of ERISA, substantive provisions which limit the alienability of pension plan benefits from a surviving spouse. In this matter, it is not asserted that a claim of negligence lodged against an HMO is in conflict with any substantive provision of ERISA.

into question.[5] We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning contained within the *Travelers* line of cases, even though we recognize that the Court's earlier cases have not been expressly overruled.

Based upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not "relate to" an ERISA plan. As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709. Claims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe

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[5] U.S. Healthcare also cites to a number of circuit court decisions which have held that claims against HMOs are preempted by ERISA. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Cannon v. Group Health Services of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996). Yet, the bulk of these cases were handed down prior to *Travelers*. The only one of these cases which was decided subsequent to *Travelers* – *Cannon* – fails even to mention *Travelers*. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions.

medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.[6]

Furthermore, we believe that negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans, as in the cases with many laws of general applicability," *Travelers*, 514 U.S. at 661, 115 S.Ct. at 680, 131 L.Ed.2d at 708-709, and therefore are not preempted. We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. As noted by the *De Buono* Court, an incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption. *De*

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[6] The Superior Court below, in reasoning that ERISA does not preempt negligence claims lodged against HMOs, stated that "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted." *Pappas v. Asbel*, 450 Pa.Super. 162, 171, 675 A.2d 711, 716 (1996). The Superior Court concluded that Congress could not have intended to preempt that which it did not know would come into existence. We find that we are unable to adopt this reasoning that the modern day HMO was unforeseen by Congress when it drafted ERISA. Just one year preceding the enactment of ERISA, Congress enacted the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq*. The HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs.

Buono, ___ U.S. at ___, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31.

For the foregoing reasons, we conclude that ERISA does not preempt the claims in question. The order of the Superior Court is affirmed.[7]

Mr. Justice Nigro files a concurring opinion.

Judgment entered
Dated: December 23, 1998

/s/ John W. Person
John W. Person, Esquire
Deputy Prothonotary

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[7] We also note that U.S. Healthcare puts great effort into arguing that it is not the negligent party here, and that Haverford and the physicians involved are solely responsible for the Pappas' injuries. U.S. Healthcare may ultimately be vindicated on these claims, but this is not the proper stage for these arguments. The issue with which we are concerned in this case is whether the claims against U.S. Healthcare are preempted; we have determined that they are not. It is now left for the fact-finder to determine if U.S. Healthcare's defenses to the negligence claims are valid.

[J-97-1997]
IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS AND THEODORA PAPPAS, H/W, Plaintiffs v. DAVID S. ASBEL, D.O., Defendant, Pennsylvania Hosp. Ins. Co. (Phico) and The Commw. of Pennsylvania Med. Professional Liab. Catastrophe Loss Fund (Cat Fund), Defendants/Appellees v. United States Healthcare Sys. of Pa., Inc., Additional Defendant/ Appellant	No. 98 Eastern District Appeal Docket 1996 Appeal from the Orders of the Superior Court filed March 15, 1996 and May 23, 1996 at No. 2617 Philadelphia 1995, reversing the Order of the Court of Common Pleas of Delaware County at No. 92-3903 450 Pa. Super 162, 675 A.2d 711 (1996) ARGUED: April 30, 1997

CONCURRING OPINION

MR. JUSTICE NIGRO DECIDED: December 23, 1998

I concur in the result reached by the Majority. I agree that the *Traveler's* line of cases in the United States Supreme Court supports the proposition that issues raising ERISA preemption are to be narrowly construed. I write separately, however, to explain why the present

negligence claim against U.S. Healthcare falls outside that narrow construction and is therefore not preempted. Here, the defendant physician and hospital brought U.S. Healthcare into the action claiming that it was U.S. Healthcare's refusal to authorize a medically necessary transfer which caused plaintiff's ultimate injury. Based upon the facts set forth in the Majority Opinion, I find that U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan. Here, the parties are merely attempting to assert their already existing rights under the generally applicable state law of agency and tort. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995), *cert. denied.*, 115 S. Ct. 564 (1995).

The federal courts have addressed issues similar to the present matter. *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990), presented an analogous situation as the injured party sued her HMO after receiving negligent medical treatment from a physician on its approved list. The *Smith* court, in finding the plaintiff's action was not preempted, stated that such a state tort action did not " 'impact upon' an employee benefit plan or 'affect the Congressional scheme contained in [ERISA]'." *Id.* at 988.

Moreover, as the Third Circuit recently explained, "patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan." *Dukes*, 57 F.3d at 358. *Dukes* explains that ERISA is principally concerned with the various mechanisms and institutions involved in the funding and payment of plan benefits and was intended

to provide each participant with a remedy in the event that promises made by the plan were not kept. *Id.* at 357. *Dukes* distinguishes between claims that the "quantum" of benefits promised were not provided, which *is* controlled by ERISA, and the "quality" of the benefits actually received, which is *not* controlled by ERISA. *Id. Dukes* concluded that "[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such." *Id.* I would adopt the rationale of the *Smith* and *Dukes* decisions and find that the negligence action against U.S. Healthcare is not preempted.

Therefore, I believe the overall purpose for the enactment of ERISA, as well as subsequent case law, would indicate that the negligence claim against U.S. Healthcare does not fall under the aegis of the preemption clause. It is for these reasons that I find state negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans. . . . " *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company et al.*, 514 U.S. 645, 661, 115 S. Ct. 1617, 1679 (1995) (citing *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 n.1, 113 S. Ct. 580, 583, n.1 (1992)).

J.A02006/96

BASILE PAPPAS & THEODORA PAPPAS, H/W/	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 2617 Philadelphia 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

ORDER

AND NOW, this 23rd day of May, 1996, IT IS HEREBY ORDERED:

THAT the application filed March 29, 1996, requesting reargument/reconsideration of the decision dated March 15, 1996 is DENIED.

PER CURIAM

J. A02006/96 – 1

BASILE PAPPAS & THEODORA PAPPAS, H/W	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 02617 PHILADELPHIA 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

Appeal from the Order Dated June 20, 1995, in the Court of Common Pleas of Delaware County, Civil Division, No. 92-3903

BEFORE: KELLY, HOFFMAN, JJ. AND MONTEMURO, J.*

JUDGMENT

ON CONSIDERATION WHEREOF, *it is now here ordered and adjudged by this Court that the judgment of the Court of Common Pleas of* DELAWARE *County be, and the*

same is hereby REVERSED AND REMANDED FOR FURTHER PROCEEDINGS.

BY THE COURT:

/s/ _____
PROTHONOTARY

Dated: MARCH 15, 1996

J. A02006/96 – 1

BASILE PAPPAS & THEODORA PAPPAS, H/W	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 02617 PHILADELPHIA 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

Appeal from the Order Dated June 20, 1995, in the Court of Common Pleas of Delaware County, Civil Division, No. 92-3903

BEFORE: KELLY, HOFFMAN, JJ. AND MONTEMURO, J.*

OPINION BY MONTEMURO, J.: FILED MAR 15 1996

This appeal lies from an order granting summary judgment to appellee, United States Healthcare, Inc. (USHC), on the basis that the third party complaint of appellant Haverford Community Hospital is preempted by Section 1144(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*

On May 20, 1990, Basile Pappas, a subscriber to USHC, an HMO provided through his wife's employment, presented himself at the offices of his primary care physician, Dr. David Asbel, complaining of neck and shoulder pain. The treatment administered was an intramuscular injection of steroids. By the next day, Mr. Pappas' condition had deteriorated significantly, and, unable to walk, complaining of numbness in his arms, chest, abdomen and legs, he was transported to appellant Haverford Community Hospital at 11:00 a.m. There, after examination and preliminary testing which revealed an abnormally elevated white blood cell count, Mr. Pappas was preliminarily diagnosed as suffering from a cervical epidural abscess which was compressing his spinal cord. Dr. Dickter, the emergency room physician responsible for Mr. Pappas' care, determined that the case constituted a neurologic emergency requiring further, immediate

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* Retired Justice assigned to Superior Court.

diagnosis and treatment at a university hospital with more extensive facilities than those available at Haverford.

After telephone consultation with Dr. Asbel, as well as Haverford's staff neurologist and neurosurgeon, arrangements were made by 12:30 to transfer Mr. Pappas to Thomas Jefferson University Hospital, which, possessing a spinal cord trauma unit, was able to assure Mr. Pappas' immediate admission. However, at 12:40 the ambulance service which was to transport Mr. Pappas informed the physicians at Haverford that as Jefferson was not an approved facility, authorization for Mr. Pappas' removal there was not forthcoming from USHC. At 12:50, Dr. Dickter telephoned USHC in an attempt to obtain authorization, and to do so quickly in view of the nature of the emergency. At 1:05, Dr. Dickter was informed by USHC that, after review, authorization for treatment at Jefferson was still being denied, but that Mr. Pappas could be removed to Hahnemann University, Temple University or Medical College of Pennsylvania. The USHC physician[1] who had made this decision refused to speak directly to Dr. Dickter, despite several requests that he do so, and after USHC was informed that Mr. Pappas' condition could worsen or become permanent. Rather, USHC's position was communicated through administrative personnel. Since Dr. Asbel expressed a preference for Hahnemann, that facility was contacted immediately but advised Haverford at about 2:20 p.m. that it would not have information on its ability

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[1] The record does not reveal the field of specialization of this physician, a Dr. Liebowitz.

to receive Mr. Pappas for at least another half hour. MCP was then reached and within minutes notified the physicians that it could accept Mr. Pappas, who was ultimately transported there at about 3:30 p.m. Mr. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Mr. Pappas brought suit against Asbel and Haverford, claiming various forms of malpractice as to the former, and as to the latter, negligence in causing an inordinate delay in transferring him to a facility equipped and immediately able to address the neurological emergency, thus exacerbating the compression of the spine which caused his quadriplegia. Haverford then filed a third party complaint against USHC, joining it as a party defendant for its refusal to authorize the transfer of Mr. Pappas to the hospital selected by the Haverford physicians, and adopting the negligence claims lodged against it in the original complaint. In his answer and new matter, Dr. Asbel filed a cross claim against USHC seeking contribution and/or indemnity. After filing both Answer and New Matter and Preliminary Objections, which failed to mention preemption, USHC successfully filed a motion for summary judgment alleging that the third party complaint should be dismissed, having been preempted by § 1144(a) of ERISA. This appeal followed,[2] presenting the question of whether ERISA was correctly determined to

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[2] Mr. Pappas' claims against Dr. Asbel and Haverford were settled by agreement of the parties, and Haverford's interests vis a vis USHC are now represented by the Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Catastrophic Loss Fund.

preempt Haverford's claim, characterized by appellant as a state law claim unrelated to ERISA or employee benefits, against USHC.[3]

In reviewing a grant of summary judgment we must determine whether, in view of the pleadings, depositions, answers to interrogatories, admissions on file, together with any affidavits, any genuine issue of material fact exists in the case, and, if not, whether the moving party is entitled to judgment as a matter of law. Moreover, the moving party's right to such a judgment must be clear and free from doubt. *Musser v. Vilsmeier Auction Co., Inc.*, 522 Pa. 367, 562 A.2d 279 (1989); Pa.R.C.P. 1035.

29 U.S.C. § 1144(a) reads in pertinent part as follows:

> Except as provided in subsection (b) of this section, the provisions of this title . . . shall

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[3] There is no question that USHC is an employee benefits plan as defined by ERISA, 29 USCS § 1002(1):

> The terms "employee welfare benefit plan" and welfare plan mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, (A) medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefits described in section 3023(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

> supersede any and all State laws *insofar as they* may now or hereafter *relate to* any employee benefit plan . . . (emphasis added).

It may, without fear of contradiction, be asserted that the Supremacy Clause, United States Constitution, Art. VI, expressly or by implication commands preemption of a state law where such law conflicts with federal law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Commission*, 461 U.S. 190 (1983). It is also well settled that ERISA's supersession provision is vast in its application. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). However, the question still remains as to the precise reach of the phrase "insofar as they . . . relate to . . . " In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the United States Supreme Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 97. The trial court in this matter found that the allegations in Haverford's third party complaint all "f[e]ll within the rubric of administration of an employee benefit plan" because they concerned specific actions taken by USHC, namely its refusal to approve Mr. Pappas' transfer to a facility where the care he needed was available immediately as the emergent nature of his condition required.

Because the limitations supplied by the cases attempting to define "relate to" are necessarily vague, the district and circuit courts which have considered the matter of HMO involvement are split on the precise extent of ERISA's reach. A number of federal court cases impose preemption on efforts to hold an HMO liable for injuries resulting from certain of its decisions on the basis

that any attempt to seek redress constitutes an attack on the administration of the HMO, the position adopted by the trial court herein, and thus imposes a restriction such as the Act seeks to avoid. *See, e.g., Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 114 S.Ct. 694 (1994) (claim against HMO for denying surgical precertification preempted by ERISA); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (1992), *cert. denied*, 113 S.Ct. 812 (1992) (claims against HMO for failure to provide hospitalization to expectant mother resulting in death of unborn child); *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (1993) (claim against HMO for refusing to precertify surgery which could only be performed at hospital outside HMO service area, causing delay in surgery resulting in death of beneficiary). All of these cases have in common the reasoning that the state law claims involved necessarily "relate to" administration of the plans in question and are therefore preempted under the broad sweep of § 1144(a).

The United States Supreme Court, however, albeit in dealing with factual settings which differ from the sorts of claims involved in these cases, has refined the "relate to" language, thus truncating it to some extent. In *Mackey v. Lanier Collection Agency and Service*, 486 U.S. 825 (1988), attendant upon a finding that a state garnishment action against participants in an ERISA plan providing vacation and holiday benefits was not preempted, the Court noted:

> ERISA plans may be sued in a second type of civil action as well. These cases – lawsuits against ERISA plans for run of the mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan – are relatively commonplace. Petitioners and

> the United States (appearing here as amicus curiae) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA § 514(a).

Id. at 833. (emphasis added).

In the recent case of *New York Blue Cross v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995), the Court has indicated that § 1144(a) may well be further limited. There, the Court examined a New York statute which requires hospitals to collect surcharges from patients covered by designated commercial insurers and imposes a surcharge on certain HMO's, but exempts from the surcharges those patients insured by a Blue Cross/Blue Shield plan. In holding that the surcharge provisions do not "relate to" employee benefit plans, the Court noted that the language of ERISA is so expansive as to be, for all practical purposes, infinite: unless read in conjunction with the structure and purpose of the statute as a whole, the words of limitation, "insofar as they . . . relate to . . . ," are not limiting at all, and Congress' intention must be interpreted as a sham. *Id.* at 1677. Rather, the Court determined to "go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* The Court then observed that "[t]he basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," *id.* at 1677-78, that is, to protect it from conflicting directives. However, the Court went on to note that "nothing in the language of the Act or the context of its passage

indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 1680. The Court extrapolated from its findings that "a law operating as an indirect source of merely economic influence on administrative decisions . . . should not suffice to trigger preemption." *Id.*

This last is especially pertinent to the question presented here despite the variance in context. What is at issue is a negligence claim identical to the one lodged against Haverford by Mr. Pappas in the underlying complaint. The type of recovery sought is based on negligence attributable to the delay occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries. Decisions such as that made by USHC concerning where Mr. Pappas might receive treatment are propelled by dollar savings, not the protection of worker's rights, in this case the right to the most effective medical care, which was the original focus of ERISA. In fact, the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations.

Considerations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted. It cannot therefore be argued that the type of recovery sought here was deliberately excluded from the Congressional scheme in order to protect ERISA plans from conflicting directives which would, in attempting to control expenses, affect medical judgments. A tort claim such as

that advanced here is, in fact, "an indirect source of merely economic influence on administrative decisions." *Id.* To find that such claims are preempted because they may interfere with what is in essence a business decision made in the financial interests of a commercial entity is inconsistent with the intention of ERISA and should not "suffice to trigger preemption." *Id.*

This conclusion is consistent with cases in which courts found that a particular state claim is not preempted, based on the rationale that the state law involved affects ERISA in an indirect manner, or is so tenuous or remote as to obviate the necessity for preemption. *Greenblatt v. Budd,* 666 F.Supp. 735, 741 (E.D. Pa. 1987) (common law action for misrepresentation by employee whose pension benefits were denied after company merger not preempted.) To make such a determination, it is the state statute which must be examined, and an assessment made of whether the action represents exercise of a classically important state function preempted neither expressly or impliedly by ERISA. *Id.* Contrast, *Memorial Hospital System v. Northbrook Life Insurance Company,* 904 F.2d 236 (5th Cir. 1009) (action for deceptive trade practices by health care provider against plan trustees not preempted, because enforcing allocation of risks between commercial entities conducting business in a state is a classically important state interest, and because health care provider is not a party to plan.) General health care regulation is, as has already been noted, traditionally an area of state concern. *New York Blue Cross, supra.*

While decisions of the federal district courts and courts of appeal, including those of the Third Circuit, are not binding on Pennsylvania courts, even where a federal

question is involved, *Breckline v. Metropolitan Life Insurance Company*, 406 Pa. 573, 578, 178 A.2d 748, 751 (1962), they are both persuasive as to federal questions, *Chiropractic Nutritional Associates, Inc. v. Empire Blue Cross and Blue Shield, Inc.*, ___ Pa. Super. ___, ___ A.2d ___ (Nos. 62-69 Pittsburgh 1995, Slip Op. at 10 filed Dec. 29, 1995), and those of the Third Circuit are appropriate for this court to follow where the United States Supreme Court has not spoken. *Id.* In *Dukes v. US Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir. 1995) (claims for direct negligence of HMO remanded to state court for determination of whether preemption was mandated),[4] the Third Circuit recognized that "Quality control of benefits . . . is a field traditionally occupied by state regulation, and we interpret the silence of Congress as reflecting an intent that it remains so." *See also, Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (1990) (state court action for medical malpractice under ostensible agency theory not preempted by ERISA).

In *Krashna v. Oliver Realty, Inc.*, 895 F.2d 111 (3d Cir. 1990), albeit in another context, the Court of Appeals for the Third Circuit stated that in order to show that what

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[4] Appellee argues that this case is inapposite as it concerned only the issue of whether it was proper to remove the case to federal court based on ERISA's preemption provision – no decision was reached as to whether this provision actually applied. However, as appellant points out, the court was not able to articulate any plan-created right that was threatened by the plaintiffs' state law negligence claims. Had it been able to do so the decision as to preemption would not even be regarded as equivocal; the claim would have been dismissed.

purports to be a state law claim is completely preempted by federal statute, two factors must be shown:

> First, "the statute relied upon by the defendant as preemptive [must] contain [ ] civil enforcement provisions within the scope of which the plaintiff's state claim falls." . . . The federal statute must subsume the interest vindicated by the state law, not the remedy provided. . . . Second, there must be "a clear indication of a Congressional intention to permit removal despite the plaintiff's exclusive reliance on state law."

Id. at 114, quoting *Railway Labor Executives Ass'n v. Pittsburgh & L.E. R.R.*, 858 F.2d 936, 942 (3d Cir. 1988). *See also, Plucinski v. I.A.M. National Pension Fund, et al.*, 875 F.2d 1052 (3d Cir. 1989) (In accountancy malpractice case brought by a plan, the conclusion was reached that ERISA does not generally preempt state professional malpractice claims.)

ERISA's civil enforcement provision, § 1132(a)(1)(B), permits beneficiaries of employee welfare plans to "recover benefits due . . . under the terms of the plan," "to enforce . . . rights under the terms of the plan or to clarify rights to future benefits under the terms of the plan." As the *Dukes* court observes,

> Inherent in the phrases "rights under the terms of the plan" and "benefits due . . . under the terms of [the] plan" is the notion that plan participants and beneficiaries will [by means of litigating tort claims] receive something to which they would not otherwise be entitled. But patients enjoy the right to be free from medical malpractice regardless of whether or not their

medical care is provided through an ERISA plan. *Id.* at 358.

This court has ruled that negligence claims are not preempted by ERISA, as they are not "related to" it. *See, McClellan v. Health Maintenance Organization of Pennsylvania,* 413 Pa. Super. 128, 604 A.2d 1053, *appeal denied,* 532 Pa. 664, 616 A.2d 985 (1992) (suit based on liability of HMO for negligence of agent/physician and on intentional misrepresentation or fraud by HMO itself); *DeGenova v. Ansel,* 382 Pa. Super. 213, 555 A.2d 147 (1988) (suit based on vicarious liability of HMO for the negligence of its agent/physician). Nor are these claims covered by ERISA's civil enforcement provisions. The *DeGenova* court specifically found that the "appellants were not seeking ERISA benefits or claiming improper distribution or administration of ERISA benefits," *Id.* at 219, 555 A.2d at 150, and thus preemption did not apply.

The negligence claims at issue here too have, in fact, no connection to the benefit scheme which Congress sought to protect by preempting laws tending to produce conflicting systemic demands; ERISA is in no way implicated by the claim that USHC negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer. Appellants do not seek benefits denied, because Mr. Pappas was transferred to a hospital capable of supplying the needed services; they do not seek to challenge the administration of the Plan, again because there is no complaint that USHC did not perform its duties. Rather, the argument is that USHC performed its duties in a negligent manner given the exigent nature of the emergency. Finally, if the original complaint had claimed that USHC was vicariously liable because of the negligence of

its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question under *McClellan* and *DeGenova* that the claim would withstand preemption.

As the *Corcoran* court points out, to conclude that the preemption of all other claims was incorporated into Congress' intent in enacting ERISA necessarily assigns to Congress the concomitant intent to deprive plaintiffs injured by such negligence of any remedy, state or federal, for serious errors perpetrated by HMO's. However, the Supreme Court of the United States, in analyzing the application of preemption clauses in other statutes, found it "difficult to believe that Congress would, without comment, remove all judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corporation*, 464 U.S. 238, 251 (1984) (Award of punitive damages arising out of escape of plutonium from federally licensed nuclear facility not preempted by Atomic Energy Act). *See also, United Construction Workers v. Laburnum Construction Corporation*, 347 U.S. 656 (1954).

We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system which inheres in USHC's review process, to foreclose recovery to plan beneficiaries injured by negligent medical decisions. We therefore conclude that the negligence claims against appellee are not preempted by ERISA.

The question then becomes what, if any, impact the procedural posture of this case has on the implementation of the preemption provision. The trial court concedes that the "no relation" theory may be a valid one, but

concludes that because Haverford Hospital and not Mr. Pappas joined USHC as a party defendant, no theory of recovery which would otherwise be available could apply. Pa.R.C.P. 2255(d) dispenses with such a distinction:

> The plaintiff shall recover from an additional defendant found liable to him alone or jointly with the defendant as though such defendant had been joined as a defendant and duly served and the initial pleading of the plaintiff had averred such liability.

See also, Solomon v. Cedar Acres East, Inc., 455 Pa. 496, 317 A.2d 283 (1974).

The effect of a third party complaint joining an additional defendant is thus to make the additional defendant "immediately subject to the plaintiff's claim in every respect and with the same force and effect as if the additional defendant had been originally named as the defendant" in the plaintiff's complaint. *3 Standard Pennsylvania Practice 2d* (1994), § 14:359. The character of the claim does not alter with the procedure used to present it.

Accordingly, we reverse the trial court's order granting summary judgment and remand for further proceedings consistent with this Opinion.

IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

BASILE PAPPAS and THEODORA PAPPAS, Plaintiffs	:	NO. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL, and UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. Defendants	:	

ORDER

KEELER, J. FILED:

AND NOW, this 3rd day of June, 1994, upon consideration of the motion for Summary Judgment filed by United States Healthcare Systems of Pennsylvania, Inc. (USHC), the various responses filed by the other parties and the memoranda submitted, it is hereby ORDERED that USHC's motion for Summary Judgment is GRANTED.

BY THE COURT:

/s/ Charles C. Keeler, J.
CHARLES C. KEELER, J.

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEODOREA PAPPAS, his wife,	:	NO. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL	:	
vs.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	

OPINION

KEELER, J. FILED:

I. FACTS

On or around May 20, 1991, the plaintiff, Basile Pappas, presented himself at the offices of Dr. David Asbel, complaining of neck and shoulder pain. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of medication. Despite this treatment, plaintiff alleges that his condition worsened. The following morning his deterioration manifest itself by rendering Mr. Pappas immobile and by causing numbness in his extremities. He was transported via ambulance to the Haverford Community Hospital ("Haverford") on the morning of May 21, 1991. The plaintiffs provided the hospital with information regarding HMO-PA in order to satisfy the hospital of financial responsibility. Both Mr. and Mrs. Pappas subscribed to HMO-PA through an

employees' health benefits plan provided to Mrs. Pappas by her employer, The Charming Shoppes. HMO-PA is owned by additional defendant U.S. Healthcare Systems of Pennsylvania, Inc. ("USHC"). He was admitted at approximately 11:00 a.m. to the hospital's emergency room. Dr. Steven J. Dickter examined Mr. Pappas and ordered a blood study. The analysis revealed an elevated white cell count. These results in conjunction with the patient's subjective complaints and physical ailments led Dr. Dickter to the conclusion that Mr. Pappas was suffering from an epidural abscess which pressed upon Mr. Pappa's spinal column.

Dr. Dickter consulted with Dr. Slater, a neurologist at Haverford who concurred that the situation constituted a neurologic emergency. This determination was also confirmed by a consultation with Dr. Yablon, a Haverford neurosurgeon. Given the circumstances, Dr. Dickter felt it would be in the patient's best interest to receive treatment at a "university" hospital. Dr. Dickter made arrangements to transfer Mr. Pappas to Jefferson University Hospital for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that Jefferson was not an approved hospital for HMO-PA. Ten minutes later, Dr. Dickter contacted HMO-PA to inquire as to Jefferson's status as an approved facility. Nearly 15 minutes later, HMO-PA responded to Dr. Dickter's inquiry and advised him that Jefferson was not an approved facility, but that the patient could be transferred either Hahnemann, Temple or Medical College of Pennsylvania ("MCP").

Dr. Dickter then telephoned Dr. Asbel and sought his preference concerning the patient's destination. Dr. Asbel

expressed a preference for treatment by Dr. Black at Hahnemann. Dr. Dickter promptly telephoned Hahnemann to advise them of the emergency situation and to secure information regarding the transfer into Dr. Black's care. After the passage of five minutes, Dr. Dickter again called and found that his contact person was still checking on intensive care unit bed space availability. At approximately 2:20 p.m. Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before any information could be provided as to Hahnemann's ability to accept Mr. Pappas as a patient. Dr. Dickter then telephoned Dr. Mucci at MCP to ascertain whether the patient could be transferred to that facility. Within ten minutes Dr. Mucci returned the call and expressed that the patient could be accepted. Ultimately, Mr. Pappas was transported to MCP.

This lawsuit was brought as a consequence of the injuries allegedly sustained by Mr. Pappas resulting from delay in treatment while Haverford's staff attempted to make appropriate arrangements for care of the plaintiff's neurologic emergency. Plaintiff alleges that the delay exacerbated his spinalcord compression which resulted in quadriplegia. Haverford filed a third party complaint joining USHC as a third party defendant for their refusal to authorize a transfer of Mr. Pappas to a hospital selected by the physicians at Haverford. Moreover, the third party complaint suggests that USHC is liable over to Haverford for any award which might result from this action. Dr. Asbel, in his answer and new matter, filed a cross claim seeking contribution and/or indemnity from the third party defendant, USHC.

II. PROCEDURAL POSTURE

Third party defendant, USHC, has filed a motion for Summary Judgment alleging that the third party complaint filed by Haverford must be dismissed under the preemption provisions of the Federal Employee Retirement Income Security Act of 1974 (ERISA). *See* 29 U.S.C. § 1001, *et seq.* (1990). Haverford has responded by asserting that this court lacks jurisdiction to either determine whether ERISA preempts state law or the substance of HMO-PA's preemption arguments.

Any intelligent analysis of the issues raised must be predicated on an understanding of the nature of the ERISA provisions and a fundamental understanding of the nature of preemption. As such, we will address those issues first.

III. DISCUSSION

As a threshold matter, the court must determine whether it has jurisdiction to render any decision in regard to the present litigation. Haverford conveniently ignores a number of cases which decided issues involving ERISA claims. Inferentially, the fact that our appellate courts would consider the substance of such matters suggests that no legal impediment exists which divests a state court of jurisdiction over such issues. *See McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied*, 532 Pa. 664, 616 A.2d 985 (1992); *DeGenova v. Ansel*, 382 Pa.Super. 213, 555 A.2d 147 (1988).

Haverford has failed to identify any specific provision of ERISA which would divest this court of jurisdiction. Instead, it directs our attention to language in the statute which provides that Federal courts, with certain exceptions, shall have exclusive jurisdiction of civil actions brought by the Secretary of Labor or by a plan's "participant, beneficiary or fiduciary." 29 U.S.C. § 1132(e)(1). Certainly, Haverford's cross-claim is in the nature of a civil action. However, Haverford cannot maintain that its third party action is brought "by the Secretary of Labor or by a plan's 'participant, beneficiary or fiduciary'." All of these parties (as defined by ERISA) are individuals. No corporate entity such as Haverford may avail itself of the exclusive jurisdiction of the Federal courts under this specific provision. *See* 29 U.S.C. § 1002(7) (participant defined), 1002(8) (beneficiary defined) & § 1109 (fiduciary defined).

Having determined that this court possesses jurisdiction to decide the preemption issue we may now address the substance of the argument.

Under the Federal Constitution legislation enacted by the Federal government "shall be the supreme Law of the Land . . . " U.S.Const.Art. VI, cl.2. Thus, any state law which conflicts with federal law is "without effect." *Maryland v. Louisiana*, 451 U.S. 725, 746, 101 S.Ct. 2114, 2128, 68 L.Ed.2d 576, 595 (1981). Nevertheless, any issue arising under the supremacy clause assumes that the historic police powers of the individual states are not to be superseded by federal legislation unless it is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947).

The intent of Congress may be "explicitly stated in the statute's language or implicitly contained in its structure in purpose." *Jones v. Rath Packing Co.*, 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604, 614 (1977). In the absence of an express congressional command, state law is preempted to the extent it conflicts with federal law. *See Pacific Gas & Elec. Co. v. Energy Resources Conservation and Development Comm'n.*, 461 U.S. 190, 204, 103 S.Ct. 1713, 1722, 75 L.Ed.2d 752, 765 (1983). State laws are also rendered ineffectual if a federal law so thoroughly occupies a legislative field as to make it reasonable to infer that Congress left no room for the States to supplement it. *Fidelity Fed. Savings & Loan Assoc'n. v. De La Cuesta*, 458 U.S. 141, 153, 102 S.Ct. 3014, 3022, 73 L.Ed.2d 664, 675 (1982).

ERISA specifically provides that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(1). The language of the ERISA statute sweeps broadly by superseding all state laws relating to any employee benefit plan. *Morales v. Trans World Airlines, Inc.*, ___ U.S. ___, 112 S.Ct. 2031, 2037, 119 L.Ed.2d 157, 168 (1992) (breadth of scope of ERISA unmistakably relies on "express preemption and construction of the phrase 'relates to' "); *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990) ("deliberately expansive"); *FMC v. Holliday*, 498 U.S. 52, 58, 111 S.Ct. 403, 407, 112 L.Ed.2nd 356, 364 (1990) ("conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490, 501 (1983) (breadth of ERISA's "preemptive reach is apparent from [its] language").

Nevertheless, the preemption clause does not bar all claims. *See* e.g. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833, 108 S.Ct. 2182, 2187, 100 L.Ed.2d 836, 846 (1988) (state garnishment of ERISA welfare Benefit Plan not preempted; such plans may be subject to suit for state law violations, contractual obligations and torts which are unrelated to the plan's administration).

The crux of the issue then seems to be whether ERISA's preemption provision which provides that any and all state laws are superseded insofar as they "relate to any employee benefit plan" bars Haverford's claims against USHC. *See* 29 U.S.C. § 1144(a). Haverford's third party complaint attempts to establish the liability of USHC by showing that USHC "refused to authorize transfer of [Mr. Pappas] . . . to a hospital selected by physicians at Haverford . . . as being able to minister to him." *See* Haverford's third party complaint at paragraph 7. In addition, the third party complaint incorporates by reference the allegations of paragraph 24 of plaintiff's original complaint. That paragraph asserted that Haverford . . . was negligent in failing to transfer [Mr. Pappas] . . . to another medical facility in a prompt and timely fashion and that Haverford . . . inordinately delayed the transfer. *See* plaintiff's complaint at paragraph 24. All of these allegations fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision. We must therefore conclude that Haverford's efforts to pursue its third party complaint are barred.

Haverford relies upon inapposite caselaw in support of its contentions. The imposition of a local income tax on

employees despite their status as ERISA participants does not implicate a relationship to any employee benefit plan in a substantive sense. *See Firestone Tire and Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987). Nor does the application of a local tax affect the administration of an employee benefit plan in any substantive sense; thus, mandating the preemption of the action. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, 47-48 (1987) (decisional common law cause of action for improper benefit claim processing barred by ERISA because it relates to employee benefit plan).

A number of courts have held that state claims are preempted by ERISA where suit is filed to hold an HMO responsible for injuries resulting from the HMO's own negligent administration of cost containment procedures and funding decisions. *Kuhl v. Lincoln Nat'l. Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ERISA preempts plaintiff's claim against HMO for denying surgical precertification), *cert. denied* 114 S.Ct. 964 (1994); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1331 (5th Cir.) (ERISA preempts claim for erroneous medical decision rendered in context of determining plan benefits, *cert denied* 113 S.Ct. 812 (1992); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290-91 (E.D.Pa 1992) (ERISA preempts direct liability claim for failure to fund medical device). In all of these cases, preemption was based upon the fact that the failure to pay a benefit claim or preapprove a procedure possessed an obvious connection or reference to a benefit plan and therefore related to it. Other courts have decided that ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability

generally or ostensible agency specifically. *Elesser, supra,* at 1290 (plaintiff's claim alleging vicarious liability of HMO for actions of position acting ostensible as HMO's agent not preempted); *Independent HMO v. Smith,* 733 F.Supp. 983, 988 (E.D.Pa. 1990) (same). These cases apply the rationale that the negligence claims have no relationship to a denial of rights under the benefit plan since they do not affect the regulatory scheme devised by Congress in ERISA. Thus, such claims are not sufficiently "related to" ERISA such as to warrant preemption. *See generally Boyd v. Albert Einstein Medical Center,* 377 Pa.Super. 609, 619-20, 547 A.2d 1229, 1234 (1988) (adopting Restatement (Second) of Agency section 267 which outlines the theory of ostensible agency). Given the procedural posture of this case and the fact that Haverford Hospital and not the plaintiff joined USHC to the action, neither of these theories is applicable in this case.

Here, Haverford Hospital seems to suggest that USHC is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under USHC's programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan. As such, Haverford's motion for Summary Judgment must be denied.

Haverford's final argument concerning ERISA's civil enforcement scheme demonstrates a basic misconception of the ERISA statute. Clearly, certain enumerated and defined parties may seek to invoke ERISA's civil enforcement remedies. 29 U.S.C. § 1132. However, Haverford seems to confuse standing to maintain an action with

preemption. The fact that ERISA provides standing to specified categories of individuals which limits redress does not translate to a waiver of preemption. In any event, as observed previously, Haverford, as a corporate entity, possesses no standing to maintain a civil action under ERISA.

For the foregoing reasons, USHC's motion for Summary Judgment was granted.

BY THE COURT:

/s/ Charles C. Keeler
CHARLES C. KEELER, J.

STEPHEN A. RYAN, P.C.
By: Stephen A. Ryan, Esquire
Identification Nos. 21645

Suite 227, Bala Pointe
111 Presidential Boulevard
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19004-1071
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Attorney for Defendant, Haverford Community Hospital

BASILE PAPPAS & THEODORA PAPPAS, his wife,	:	COURT OF COMMON PLEAS
v.	:	
DAVID S. ASBEL, D.O.	:	DELAWARE COUNTY, PA
and	:	
HAVERFORD COMMUNITY HOSPITAL	:	
(Defendant & Third Party Plaintiff)	:	NO. 92-3903
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
(Third Party Defendant)	:	

ORDER

Having been apprised that Plaintiffs have entered into an Agreement of Settlement of the above lawsuit

with Defendants, David S. Asbel, D.O. and Haverford Community Hospital, and the details thereof; and that Plaintiffs have agreed to execute a Release in a form acceptable to said Defendants and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund"), Plaintiffs' counsel to be party to a part thereof;

It is the opinion of this Court that said Settlement is not only fair, but reasonable to all parties.

In view thereof, it is hereby ORDERED AND DECREED:

1. Defendant(s) may file an amended answer(s) asserting the Release and that they have discharged the common liability of all persons and entities;

2. Pennsylvania Hospital Insurance Company (PHICO) and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") are hereby substituted for Haverford Community Hospital as the real parties in interest;

3. Under the present circumstances, the Order of this Court dated June 8, 1994, denying the application of Haverford Community Hospital for a determination of finality of its June 3, 1994 Order granting Summary Judgment to Third-Party Defendant, U.S. HealthCare Systems of Pennsylvania, Inc. is vacated, and the application for a determination of finality is hereby granted, for the purpose of pursuing a determination of Assignees' claims for contribution and indemnity.

/s/ Charles C. Keeler, J.
J. 6/13/95

BEASLEY, CASEY, COLLERAN, ERBSTEIN, THISTLE & KLINE
BY: JAMES E. COLLERAN, ESQUIRE
ATTORNEY FOR: PLAINTIFFS
IDENTIFICATION NO. 09367
1125-35 WALNUT STREET
PHILADELPHA, PA 19107-4997
592-1000

BASILE PAPPAS and THEODORA PAPPAS, his wife, 3421 West Chester Pike Newtown Square, PA 19073	:	COURT OF COMMON PLEAS DELAWARE COUNTY CIVIL ACTION - LAW JURY TRIAL DEMANDED NO. 92-3903
Plaintiffs,	:	
vs.	:	
DAVID S. ASBEL, D.O. 3501 West Chester Pike Suite 101 Newtown Square, PA 19073	:	
and	:	
THE HAVERFORD COMMUNITY HOSPITAL 2000 Old West Chester Pike Havertown, PA 19083	:	
Defendants.	:	

CIVIL ACTION (COMPLAINT)

1. The plaintiffs are Basile and Theodora Pappas, individuals, citizens and residents of the Commonwealth

of Pennsylvania, residing therein at 3421 West Chester Pike, Newtown Square, PA 19073. Husband-plaintiff Basile Pappas brings a claim for direct personal physical and mental injury, and his wife, Theodora Pappas, brings a derivative claim, for loss of consortium and related damages, as will be described hereafter.

2. Defendant David S. Asbel, D.O. is an osteopathic physician, duly authorized and licensed to practice medicine within the Commonwealth of Pennsylvania, with offices at 3501 West Chester Pike, Newtown Square, PA 19073. At various material to the events described within this Complaint, defendant Dr. Asbel was the treating family physician of plaintiff Basile Pappas.

3. On May 20, 1991, Basile Pappas went to the offices of the defendant Dr. Asbel, and complained to Dr. Asbel of severe neck and shoulder pain of several days' duration. Mr. Pappas also informed Dr. Asbel that he was quite concerned over his condition because he had begun to experience bizarre feelings in his arms and legs, with onset of weakness of the extremities on that morning.

4. On May 20, 1991, defendant Dr. Asbel performed an intramuscular (IM) injection of plaintiff's neck, and advised him that he had administered steroids into the neck. On that occasion, Dr. Asbel prescribed Soma Compound with codeine to be taken by the patient, and informed the patient that he had somatic dysfunction.

5. After the office visit, the plaintiff returned home and continued to experience his ongoing severe neck pain, shoulder pain, weakness of extremities, altered and peculiar sensation within the extremities, and loss of well-being.

6. In the evening of May 20, 1991, when plaintiff's condition appeared to be progressing and deteriorating, his wife, Theodora Pappas, called the offices of the defendant, who returned her call. During that telephone conversation, Mrs. Pappas informed Dr. Asbel that her husband was experiencing worsening of the feeling of numbness of his extremities, that his extremities were ice-cold, that he had severe neck pain, that both she and her husband were very concerned about his situation, and Mrs. Pappas asked Dr. Asbel to do what was necessary.

7. During the conversation described in the preceding paragraph, defendant Dr. Asbel advised Mrs. Pappas to call him in the morning if Mr. Pappas was not better.

8. During the early morning hours of May 21, 1991, when plaintiff's condition continued to deteriorate, and when he was unable to void, Mrs. Pappas once again contacted Dr. Asbel, who repeated instructions to call him in the morning if Mr. Pappas was no better.

9. In the early morning of May 21, 1991, Mrs. Pappas again contacted Dr. Asbel, and told him that her husband was unable to move, had complete numbness of all extremities, as well as other signs and symptoms then present. On that occasion, Dr. Asbel informed Mrs. Pappas to summon an ambulance, and to have her husband taken to the Haverford Community Hospital.

10. The ambulance crew of the ambulance summoned took a great deal of time in making Mr. Papas ready for ambulance transportation to the Haverford Community Hospital, where he was admitted at 11:01 a.m. on May 21, 1991.

11. Mr. Pappas was admitted to Haverford Community Hospital on a stretcher, alert and verbally responsive, complaining of neck pain since May 17th, which had been treated by Dr. Asbel on May 20th with a steroid injection into the left cervical region. The admission history recorded that Mr. Pappas was presently unable to walk. Emergency room personnel contacted Dr. Asbel for instructions.

12. Plaintiff remained at the Haverford Community Hospital from 11:00 a.m. until he was transferred to the Medical College of Pennsylvania (MCP) at or about 3:30 p.m.

13. While the patient was at Haverford Community Hospital, the physicians there made a probable diagnosis of cervical epidural abscess, requiring neurosurgical decompression.

14. While Mr. Pappas remained at the Haverford Community Hospital, physicians there attempted to place him at a university hospital, where surgical decompression could be done.

15. X-rays done of the plaintiff while he as at Haverford Community Hospital showed hypertrophic spondylosis of the cervical spine with disc space narrowing at the level of C-5/C-6.

16. Mr. Pappas was admitted to the emergency room of the Medical College of Pennsylvania (MCP) at or about 4:04 p.m. on May 21, 1991, in a condition of quadriplegia. On admission there, the plaintiff gave a history of gradual onset of weakness beginning the previous day

(May 20th). The patient also gave a history of a deterioration of his condition on May 20th, to the point where he became unable to void on May 20th.

17. Mr. Pappas was admitted to the service of Warren Goldman and David Swingle, both neurosurgeons. An emergency myelogram showed a complete block at the level of C-6.

18. Mr. Pappas was brought to surgery by David Swingle, M.D. on the evening of May 21, 1991. He underwent cervical laminectomies at the levels of C-2/C-6, inclusive. His quadriplegia was determined to have been caused by spinal cord compression by an epidural abscess, which subsequently grew out cultures positive for staph aureus.

19. Pathological study of the surgical specimens, including bone chips, proved the diagnosis to be cervical epidural abscess.

20. The patient remanded quadriplegic and was discharged from MCP, and then admitted to the Magee Rehabilitation Hospital, where he was confined until discharged on June 3, 1991.

21. On June 3, 1991, Mr. Pappas was re-admitted to MCP, where he was confined until discharged on June 28, 1991. During this admission, the patient remained quadriplegic as a result of spinal compression caused by an epidural abscess. The patient was admitted because of fever thought to be due to urinary tract infection, and for workup for the possibility of spinal meningitis.

22. Basile Pappas remains permanently and irreversibly paralyzed in his lower extremities, with loss of

bowel and bladder and sexual function; and remains significantly paralyzed in his upper extremities, with only return of partial upper extremity function. Mr. Pappas' upper extremities are tight, and spastic, consistent with major neurologic injury.

23. The negligence of the defendant David S. Asbel, D.O. consisted of the following:

a. Failing to do a complete and thorough neurological examination of Mr. Pappas in his office on May 20, 1991, given the signs and symptoms of plaintiff's presentation and history;

b. Failing to diagnose and recognize neurologic deficits affecting plaintiff's body on May 20, 1991;

c. Failing to take a complete and thorough history from Mr. Pappas on May 20, 1991;

d. Failing to admit Mr. Pappas to the hospital on an urgent basis on May 20, 1991, for immediate myelogram, CAT Scans, MRI's, neurological and neurosurgical consultations, and immediate surgery, all for a presumptive diagnosis of spinal cord compression, probably related to an epidural abscess;

e. Failing to inform and advise the patient on May 20th of the serious implications of his presentation, and of the need for urgent and emergent hospitalization with probable need for surgery;

f. Injecting the patient's neck with steroid preparations, all in contravention to what medical standards would have dictated at the time, given the neurologic components of patient's signs and symptoms;

g. Breach of sterile technique in the injection previously described, as a result of which defendant did, or may have, pushed staph infection into the patient's spinal canal;

h. Completely reassuring the patient concerning the nature of the condition causing his signs and symptoms, by affirmatively stating to the patient that he had somatic dysfunction, which would respond favorable to the injection, and to medications prescribed on that visit;

i. Giving the patient completely inadequate instructions concerning what to look for in the aftermath of the office visit, especially as those instructions should have alerted the patient to watch for progression of neurologic signs and symptoms, and other changes in his condition;

j. Failing, once again, to respond adequately to patient's signs and symptoms and continuing deterioration, on the occasion when Mrs. Pappas called him during the evening of May 20, 1991, and reported continuation of extremity weakness, numbness, and neurologic deterioration;

k. Failure thereafter to respond adequately, and to diagnose the patient as having probable spinal cord compression, based upon information already known to the patient, and information communicated to him prior to patient's hospitalization and 'Haverford Community Hospital;

l. Abandoning the patient, by refusing to intervene in response to telephone communications from Mrs.

Pappas, which communicated information should have caused the defendant to realize the patient's need for prompt, urgent hospitalization, and for immediate workup for presumed spinal cord compression;

m. Failing to respond adequately when contacted by personnel of the Haverford Community Hospital, and to make immediate steps to have the patient admitted to a hospital competent and experienced to perform the necessary surgery;

n. Allowing plaintiff's spinal cord compression to go unrecognized and undiagnosed, during all of which time the condition was caused to deteriorate progressively, with the result that the patient became permanently quadriplegic because of lack of proper medical and surgical intervention;

o. Prescribing medications to the patient on May 20th, which were contra-indicated.

24. The negligence of the defendant Haverford Community Hospital, acting through its authorized agents, servants and employees, including emergency room personnel, house physicians, medical staff members, nurses, radiologists, and other types of healthcare professionals, consisted of the following:

a. Failing to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. Delaying inordinately in transferring the patient, keeping him at the Haverford Community Hospital during which time his spinal cord compression

continued, with resulting permanent damage to the patient's spinal cord.

25. At all times material to this Complaint, the plaintiffs acted with due care and were not contributorily negligent.

COUNT I – BASILE PAPPAS v. DEFENDANTS

26. Plaintiff incorporates by reference each and every paragraph of this Complaint which has preceded this Count, as if each such paragraph were individually set forth within this Count.

27. As a result of the negligence of the defendants, the plaintiff has sustained quadriplegia, loss of the function of his extremities, loss of bowel and bladder function, loss of sexual capacity, is a complete invalid, requiring constant care and attention for the most basic bodily needs; has suffered extreme mental illness and anxiety, including depression, fear, sadness, loss of interest in life's pleasures and activities, and related psychic damage; and has suffered loss of enjoyment of life, has required multiple hospitalizations and medical and surgical treatments, and is subject to ongoing need for medical and surgical therapies throughout his life, together with constant care for his debilitated condition of mind and body.

28. As a result of the negligence of the defendants, the plaintiff has and will continue to sustain for the rest of his life great bodily pain and suffering.

29. As a result of the negligence of the defendants, the plaintiff has and will forever suffer mental illness, depression and anxiety.

30. As a result of the negligence of the defendants, the plaintiff has and will continue to incur large medical and related bills for ongoing care and therapy.

31. As a result of the negligence of the defendants, the plaintiff has lost his livelihood, his earnings, and his earning capacity, with grave economic and financial implications.

32. As a result of the negligence of the defendants, the plaintiff has suffered the loss of the enjoyment of his life, inconvenience, disruption of his daily habits and pursuits, and permanent loss of happiness.

33. As a result of the negligence of the defendants, the plaintiff has suffered permanent embarrassment, humiliation, and scarring of mind and body.

34. As a result of the negligence of the defendants, the plaintiff is now totally dependent upon his wife and others.

WHEREFORE, plaintiff claims judgment against each defendant in a sum in excess of $20,000.00, exclusive of interest and costs.

COUNT II – THEODORA PAPPAS v. DEFENDANTS

35. Plaintiff incorporates by reference all of the preceding paragraphs of this Complaint, including those of Count I, as if each such paragraph were individually set forth within this Count.

36. As a result of the negligence of the defendants, the plaintiff has and will continue to suffer a loss of consortium, and has and will continue to suffer a disruption of her daily habits and pursuits, and alteration in her own lifestyle, and will need to render constant care and attention to her debilitated husband.

WHEREFORE, plaintiff demands judgment against each defendant in a sum in excess of $20,000.00, exclusive of interest and costs.

BEASLEY, CASEY, COLLERAN, ERBSTEIN, THISTLE & KLINE

BY: /s/ James E. Colleran
JAMES E. COLLERAN, ESQUIRE
Attorney for Plaintiffs

COMMONWEALTH OF PENNSYLVANIA : SS
COUNTY OF PHILADELPHIA :

Basile Pappas, being duly sworn according to law, deposes and says that he is the plaintiff herein and that the facts set forth in the foregoing pleading are true and correct to the best of his knowledge, information and belief.

x Basile Pappas
BASILE PAPPAS

Sworn to and Subscribed :

Before me this 12th day :

Of March A.D., 1992 :

/s/ Anita S. Markovitz
Notary Public

Notary Seal
Anita S. Markovic, Notary Public
Philadelphia, Philadelphia County
My Commission Expires Feb. 15, 1993

BASILE PAPPAS and THEODORA PAPPAS, his wife	:	DELAWARE COUNTY COURT OF COMMON PLEAS
v.	:	CIVIL ACTION – LAW
DAVID S. ASBEL, D.O.,	:	NO. 92-3903
Defendant	:	
and	:	
HAVERFORD COMMUNITY HOSPITAL,	:	JURY TRIAL DEMANDED
Defendant and Third-Party Plaintiff	:	
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. 980 Jolly Road Blue Bell, PA 19422	:	
Third-Party Defendant	:	

THIRD-PARTY COMPLAINT

1. Plaintiffs, Basile Pappas and Theodora Pappas, have filed a Complaint against defendants, David S. Asbel, D.O. and Haverford Community Hospital, a copy of which is attached hereto and marked Exhibit A.

2. Defendant, third-party plaintiff, Haverford Community Hospital, has filed an Answer and New Matter Pursuant to Pa.R.C.P. 2252(d) to said Complaint, copy of which is attached hereto and marked Exhibit B.

3. Third-party defendant, United States Healthcare Systems of Pennsylvania, Inc. is a duly organized Pennsylvania corporation doing business in the Commonwealth of Pennsylvania and in Delaware County.

4. Third-party defendant operates and controls a health maintenance organization known as Health Maintenance Organization of Pennsylvania (HMO-PA).

5. Husband-plaintiff was, at all times pertinent hereto, a subscriber in HMO-PA.

6. Third-party plaintiff incorporates by reference the allegations of paragraph 24 of plaintiffs' Complaint, and its Answer thereto as if fully set forth in their entirety.

7. HMO-PA refused to authorize transfer of husband-plaintiff to a hospital selected by physicians at Haverford Community Hospital as being able to minister to husband-plaintiff's condition.

8. If plaintiffs receive an award or verdict in their favor based on the allegations of paragraph 24 of the Complaint, then, in such event, third-party defendant is liable over to third-party plaintiff for the amount of said award or verdict.

WHEREFORE, defendant and third-party plaintiff, Haverford Community Hospital, demands judgment against third-party defendant, United States Healthcare Systems of Pennsylvania, Inc., for all sums adjudged

against Haverford Community Hospital in favor of plaintiffs.

MASTERSON, BRAUMFELD,
HIMSWORTH & MAGUIRE

BY: /s/ Jerome E. Ornsteen
Jerome E. Ornsteen
Attorneys for Defendant
Haverford Community
Hospital

VERIFICATION

I hereby verify and state that I am associated with the law firm of Masterson, Braunfeld, Himsworth & Maguire, attorneys for Haverford Community Hospital, one of the defendants in this matter, that I am authorized to take this Verification on its behalf, that the facts set forth in the foregoing Third-Party Complaint are true and correct to the best of my knowledge, information and belief, and that I understand that these facts are subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

/s/ Jerome E. Ornsteen
JEROME E. ORNSTEEN

DATED: April 6, 1992

[J-97-97]

IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS AND THEODORA PAPPAS, H/W V. DAVID ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),	:	No. 98 ED Appeal Dkt. 96
Appellees	:	Petition for Reconsideration/ Reargument
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,	:	
Appellant	:	

ORDER

PER CURIAM:

AND NOW, this 12th day of February, 1999, Appellant's Petition for Reconsideration/Reargument is hereby DENIED.

TRUE COPY FROM RECORD

Attest FEB 12, 1999

/s/ Patricia Johnson
Patricia Johnson, Chief Clerk
Supreme Court of Pennsylvania,
Eastern District